PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2007 - 2009
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

License No._____

File No._____

(For Board Use Only)

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

_____ ACTIVE STATUS $850.00 *********(**Save $50.00 and renew on-line!**)
_____ INACTIVE STATUS $450.00……(***INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE, INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA***)
_____ I REQUEST NON-RENEWAL OF MY LICENSE*
(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

Request for NON-RENEWAL of License to Practice Medicine In Nevada

I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.

By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the Board office.

_____ _____
Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2007. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2007 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty completed during the period July 1, 2005 through June 30, 2007. **Be advised, you may be included in a random audit for review of completion of your CME's following the July 1, 2007 renewal. Please retain your CME's**

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

E-mail address_____

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name_____

Street_____

City_____County_____State_____Zip_____

Phone Number_____

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	44	NEUROLOGY	86	PEDIATRIC, UROLOGY
2	ADOLESCENT MEDICINE	45	NEURO-OPHTHALMOLOGY	87	PEDIATRICS
3	AEROSPACE MEDICINE	46	NEUROPATHOLOGY	88	PHYSICAL MEDICINE/REHABILITATION
4	ALLERGY	47	NEURORADIOLOGY	89	PREVENTIVE MEDICINE
5	ALLERGY/IMMUNOLOGY	48	NEUROTOLOGY	90	PSYCHIATRY
6	AMBULATORY MEDICINE	49	NON-CONVENTIONAL MEDICINE	91	PSYCHOANALYSIS
7	ANESTHESIOLOGY	50	NUCLEAR MEDICINE	92	PSYCHOMATIC MEDICINE
8	BLOODBANKING	51	NUTRITION	93	PUBLIC HEALTH
9	BRONCO-ESOPHAGOLOGY	52	OBSTETRICS	94	PULMONARY DISEASES
10	CARDIOVASCULAR DISEASES	53	OBSTETRICS/GYNECOLOGY	95	OCCUPATIONAL MEDICINE
11	CATSCAN/ULTRASOUND	54	OCCUPATIONAL MEDICINE	96	RADIOLOGY
12	CHILD NEUROLOGY	55	ONCOLOGY	97	RADIOLOGY, DIAGNOSTIC
13	CHILD PSYCHIATRY	56	ONCOLOGY, GYNECOLOGICAL	98	RADIOLOGY, INTERVENTIONAL
14	CLINICAL PHARMACOLOGY	57	ONCOLOGY, HEMATOLOGY	99	RADIOLOGY, NUCLEAR
15	CRITICAL CARE	58	ONCOLOGY, RADIATION	100	RADIOLOGY, THERAPEUTIC
16	DERMATOLOGY	59	ONCOLOGY, SURGICAL	101	RADIOLOGY, VASCULAR
17	DERMATOPATHOLOGY	60	OPHTHALMOLOGY	102	RHEUMATOLOGY
18	EMERGENCY MEDICINE	61	OTOLARYNGOLOGY	103	RHINOLOGY
19	ENDOCRINOLOGY	62	OTOLOGY	104	SLEEP DISORDERS
20	FAMILY PRACTICE	63	PAIN MANAGEMENT	105	SPORTS MEDICINE
21	FORENSIC MEDICINE	64	PATHOLOGY	106	SURGERY, ABDOMINAL
22	GASTROENTEROLOGY	65	PATHOLOGY, ANATOMIC	107	SURGERY, CARDIOTHORACIC
23	GENERAL PRACTICE	66	PATHOLOGY, CLINICAL	108	SURGERY, CARDIOVASCULAR
24	GERIATRIC PSYCHIATRY	67	PATHOLOGY, FORENSIC	109	SURGERY, COLON/RECTAL
25	GERIATRICS	68	PEDIATRIC, ALLERGY	110	SURGERY, CRANIOFACIAL
26	GYNECOLOGY	69	PEDIATRIC, ANESTHESIOLOGY	111	SURGERY, GENERAL
27	HAIR TRANSPLANTATION	70	PEDIATRIC, CARDIOLOGY	112	SURGERY, HAND
28	HEMATOLOGY	71	PEDIATRIC, CRITICAL CARE	113	SURGERY, HEAD/NECK
29	HOMEOPATHY	72	PEDIATRIC, EMERGENCY MEDICINE	114	SURGERY, MAXILLOFACIAL
30	HYPNOSIS	73	PEDIATRIC, ENDOCRINOLOGY	115	SURGERY, NEUROLOGICAL
31	IMMUNOLOGY	74	PEDIATRIC, GASTROENTEROLOGY	116	SURGERY, ORTHOPEDIC
32	INFECTIOUS DISEASES	75	PEDIATRIC, HEMATOLOGY/ONCOLOGY	117	SURGERY, PLASTIC
33	INFERTILITY	76	PEDIATRIC, INFECTIOUS DISEASES	118	SURGERY, THORACIC
34	INTERNAL MEDICINE	77	PEDIATRIC, INTENSIVIST	119	SURGERT, TRANSPLANT
35	LARYNGOLOGY	78	PEDIATRIC, NEPHROLOGY	120	SURGERY, TRAUMATIC
36	LEGAL MEDICINE	79	PEDIATRIC, NEUROLOGY	121	SURGERY, UROLOGIC
37	MATERNAL/FETAL MEDICINE	80	PEDIATRIC, OPHTHALMOLOGY	122	SURGERY, VASCULAR
38	MEDICAL ACUPUNCTURE			123	TOXICOLOGY
39	MEDICAL ETHICS	81	PEDIATRIC, PHYSIATRY	124	TRANSPLANTATION
40	MEDICAL GENETICS	82	PEDIATRIC, PULMONARY	125	URGENT CARE
41	NEO/PERINATAL MEDICINE	83	PEDIATRIC, RADIOLOGY	126	UROLOGY
42	NEOPLASTIC DISEASES	84	PEDIATRIC, RHEUMATOLOGY		
43	NEPHROLOGY	85	PEDIATRIC, SURGERY		

Code **Code**

Primary Scope of Practice _____ **Secondary Scope of Practice** _____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

	Date of Initial Certification	**Date of Last Recertification**
Board_____	(Mo./Yr.)	(Mo./Yr.)
Subboard_____	(Mo./Yr.)	(Mo./Yr.)

All of the following questions refer to the time period July 1, 2005, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____Yes _____No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No _____N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes _____No _____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____Yes _____No _____N/A

5. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? _____Yes _____No

6. Have you been investigated for, arrested, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest even if the ultimate disposition was dismissal or expungement. _____Yes _____No

7. Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes _____No

8. Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

9. Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes _____No

10. Have you been denied membership or expelled from a medical society or other professional medical organization? _____Yes _____No

11. Have you been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? _____Yes _____No

12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes _____No

13. Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? _____Yes _____No

14. Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services? _____Yes _____No

15. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) (If more space is needed, attach a separate sheet)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2005 through June 30, 2007;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2006 through June 30, 2006, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2006 through December 31, 2006, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2007 through June 30, 2007, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2005 through June 30, 2007.

- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2005 THROUGH JUNE 30, 2007, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE _____ HAVE NOT _____ *(CHECK ONE)* ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:
I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I UNDERSTAND HAVE ANSWERED THE QUESTIONS TRUE TO THE BEST OF MY KNOWLEDGE.

_____Yes _____No

_____ _____

Date **Signature (SIGNATURE STAMP UNACCEPTABLE)**